HCFA MEDICARE • MEDICAID Health Care Financing Administration

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HEALTH watch

Contract to Ensure Private Insurance Companies Pay Their Share of Claims

Further expanding the Clinton Administration's campaign against waste, fraud and abuse, HCFA announced in December 1999 its first-ever national contract to ensure that Medicare does not pay health care claims that are the responsibility of private insurance companies.

The contract will help Medicare increase the roughly $3 billion that it saves each year by ensuring that private insurance companies pay their share of Medicare beneficiaries' health care bills. By consolidating these efforts into a single contract, HCFA also expects to improve service to Medicare beneficiaries, health care providers, insurance companies and employers.

Many of the 39 million elderly and disabled Americans who receive Medicare benefits have other insurance that covers some of their health care costs. The other insurance companies are often legally responsible for paying certain claims before they are submitted to Medicare.

HCFA's first national Coordinaton of Benefits contractor will be Group Health Inc. In the past, Medicare's benefits coordination efforts have been carried out by a variety of contractors.

HCFA obtained the authority to hire a national Coordination of Benefits contractor as part of the Medicare Integrity Program, which was created by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

See **CLAIMS,** page 5

Universal Prescription Drug Benefit Necessary to Ensure Affordable Coverage for All Medicare Beneficiaries

Medicare beneficiaries who do not have prescription drug coverage fill fewer prescriptions and have higher cost out-of-pocket drug expenditures than beneficiaries with coverage, according to an annual study by the Health Care Financing Administration (HCFA). These findings are consistent without regard to age, gender, race, or income.

The results, published in the March/April edition of *Health Affairs*, are based on data from the 1996 Medicare Current Beneficiary Survey, the most current survey of Medicare beneficiaries. More than 11,000 Medicare beneficiaries were interviewed for this survey.

The analysis shows that almost one-third of seniors have no drug coverage at all, contributing to low medication use and high out-of-pocket spending. Although this proportion decreased by four percent between 1995 and 1996, recent month-by-month analysis of coverage suggests that it may have reached a high-water mark in mid-1996.

"Every Medicare beneficiary, whether they are covered by original fee-for-service Medicare or enrolled in a Medicare managed care plan, must be able to get the medications they need," said HCFA Administrator Nancy-Ann DeParle. "Sixty percent of Medicare beneficiaries lack dependable coverage, only 50 percent have year-round coverage, and 31 percent have no drug coverage at all. Many beneficiaries must pay for essential medicines fully out of their own pockets and are forced to pay full retail prices because they do not get the generous discounts offered to insurers and other large purchasers. The result is that many go without the medicines they need to keep them healthy and out of the hospital."

According to the HCFA report, the differences between those with drug coverage and those without continues to grow. In 1995, beneficiaries without drug coverage spent $259 less for drugs than those with coverage. In 1995, non-covered beneficiaries spent $463 on prescriptions while covered beneficiaries spent only $253 out-of-pocket.

HCFA also found beneficiaries without coverage are still receiving 25 percent fewer prescriptions less than their covered peers.

"Every Medicare beneficiary must have access to prescription drugs," said DeParle. "We must not limit a benefit to those with low incomes or in certain geographic areas. Adding a meaningful voluntary drug benefit to Medicare is not an option — it is an obligation."◆

HCFA HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

MISSION

We assure health care security for beneficiaries.

VISION

In the stewardship of our programs, we lead the Nation's health care system toward improved health for all.

GOALS

• Protect and improve beneficiary health and satisfaction • Promote the fiscal integrity of HCFA programs • Purchase the best value health care for beneficiaries • Promote beneficiary and public understanding of HCFA and its programs • Foster excellence in the design and administration of HCFA's programs • Provide leadership in the broader public interest to improve health.

OBJECTIVES

Customer Service

• Improve beneficiary satisfaction with programs, services and care • Enhance beneficiary program protections • Increase the usefulness of communications with constituents, partners, and stakeholders • Ensure that programs and services respond to the health care needs of beneficiaries.

Quality of Care

• Improve health outcomes • Improve access to services for underserved and vulnerable beneficiary populations • Protect beneficiaries from substandard care.

Program Administration

• Build a high quality, customer-focused team • Enhance program safeguards • Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds • Increase public knowledge of the financing and delivery of health care • Improve HCFA's management of information systems/technology.

NANCY-ANN DEPARLE, *Administrator*

ELIZABETH CUSICK, *Director,*
Office of Communications &
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You may browse past issues of the *HCFA Health Watch* at ***www.hcfa.gov/news/newsltrs/newsltr.htm***. Also, should you wish to make an address change or comment on an article, send your E-mail to ***healthwatch@hcfa.gov***.

Message from the Administrator

NANCY-ANN DEPARLE

MAKING THE PROGRAMS HCFA operates friendly and easy to use for the millions of Medicare beneficiaries we serve has always been a high commitment for us. Now, we have confirmation from the National Partnership for Reinventing Government (NPR) that we are succeeding.

HCFA received high marks in NPR's first-ever "customer satisfaction" survey of federal agencies. The American Consumer Satisfaction Index, a survey of the University of Michigan Business School, the American Society for Quality and the accounting and consulting firm Arthur Andersen, have done with private sector consumers since 1994 and this year added 29 high impact federal agencies, including HCFA.

In two areas our scores were truly outstanding. We got an 88 for the ease of Medicare enrollment and 85 for courteous and professional service. Our overall satisfaction index score of 71 is above the government average of 68.6 and compares very favorably to the private sector average of 72.

Reaching this high level of customer service didn't come easy. It took a lot of work from our talented and dedicated staff. And it reflects a major overhaul in the way HCFA is organized and how it does its work.

It began with a complete reorganization of our agency to focus on serving beneficiaries.

A showpiece of this new HCFA is our Center for Beneficiary Services. This is the first time HCFA has one of its major components dedicated solely to serving our beneficiaries. Among CBS's notable achievements are a toll-free telephone helpline that really works — 1-800-MEDICARE (1-800-633-4227), and an Internet web site, ***www.medicare.gov***, dedicated to providing helpful information to beneficiaries, and those who help them make health care decisions, including health care providers. Less than two years old, this outstanding web site has won a dozen awards and commendations.

Our national Medicare Education Program is in full swing and is making more and more information available to Medicare beneficiaries across the country. A centerpiece of this initiative is a new *Medicare & You 2000* handbook sent to every beneficiary household.

Many beneficiaries have told us they use the handbook as a reference guide. They put it aside for use when they need it. So, we added a summary and highlights in the first three pages. *Medicare & You 2000* includes a sample of quality and beneficiary satisfaction information.

Another key to our new look is found in the outstanding talent and private sector leadership we have added to our experienced and dedicated staff. I am particularly proud of the fact that in the past year we have doubled the number of physicians at HCFA and hired some 450 new employees to replace retirees, fill new positions and provide us with fresh private sector insight and expertise.

These are just some of the things we have done to make HCFA more responsive to the needs of the people who benefit from our programs — our customers. And we're not stopping there. Customer service is going to be just as high a priority in the new millennium as it was in the last.

More Managed Care Plans Offered to Medicare Beneficiaries

HCFA has recently approved several more Managed Care coverage plans to serve beneficiaries. Many of the plans listed in the table below have already begun offering plans as of January 1, 2000, in several service areas throughout the country.

The total number of applications for new service or expanded service areas stands at 33, with seven applications pending.

Managed care and other new health care options, known as Medicare+Choice, are available where private companies choose to offer them. Currently, about 6.5 million Medicare beneficiaries — out of a total of nearly 40 million aged and disabled Americans — have enrolled in Medicare HMOs. Original fee-for-service Medicare, currently chosen by 33 million Medicare beneficiaries, is available to all beneficiaries.

Congress created Medicare+Choice in the Balanced Budget Act of 1997 to expand the types of health care options available to Medicare beneficiaries. As part of Medicare+Choice, Medicare now offers new preventive benefits and patient protections, as well as a far-reaching information program that includes a national toll-free phone number — 1-800-MEDICARE (1-800-633-4227; a new Internet web site — ***http://www.medicare.gov***, and a coalition of more than 200 national and local organizations to provide seniors more information.

Some of the Managed Care health care plans approved by HCFA since late November 1999 are listed.

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Managed Care Provider	Locality	Beneficiaries in Service Area
Managed Health Inc. New York, N.Y.	The Manhattan-based health care company does business as HealthFirst, Inc. It began enrolling Medicare beneficiaries on April 1, 2000, with a starting date of services on May 1, 2000.	600,000 Medicare beneficiaries live in the plan's service area of the Bronx, Brooklyn and Staten Island.
Blue Cross Blue Shield of Delaware Wilmington, Del.	Enrollment for eligible Medicare beneficiaries from employer groups began on April 1, 2000. Individuals may sign up during the annual open enrollment period in November 2000.	204,000 commercial members under various programs are currently covered.
Family Health Care Plus Inc. Jackson, Miss.	Harrison County, Biloxi and Gulfport.	28,000
Sioux Valley Health Plan of Minnesota Sioux Falls, S.D.	Cottonwood, Jackson, Lyon, Murray, Nobles, Rock and Yellow Medicine counties.	20,000
Sioux Valley Health Plan Sioux Falls, S.D.	Clay, Codington, Day, Deuel, Lincoln, McCook, Minnehaha, Turner and Union counties in South Dakota, and Lyon, O'Brien, Osceola and Sioux counties in Iowa.	50,000
Well Care HMO Inc. Tampa, Fla.	Miami, Ft. Lauderdale, St. Petersburg, Tampa and Orlando areas, including Miami-Dade, Broward, Palm Beach, Hillsborough, Pinellas, Orange, Osceola and Seminole counties.	1.2 million
Blue Cross Blue Shield United of Wisconsin Milwaukee, Wisc.	The new service area is Racine County. The plan will continue to serve beneficiaries in Dane, Milwaukee, Kenosha, Ozaukee, Walworth, Washington and Waukesha counties.	28,400 including 2,000 who had previously been enrolled in another plan in the service area.
Central Oregon Independent Health Services Bend, Ore.	The new service area includes Hood River, Sherman, Wasco and Klamath counties. Clear Choice Health Plan will continue to serve beneficiaries in Crook, Deschutes, Grant, Harney, Jefferson, Lake and Wheeler counties.	18,500

Problem Nursing Homes to Face Immediate Sanctions

Nursing homes that fail to protect residents from harm will face immediate penalties, and consumers will have access to more information about the quality of nursing-home care, the Health Care Financing Administration (HCFA) announced recently.

HCFA Administrator Nancy-Ann DeParle said these new steps represent the latest in an ongoing effort to ensure that Americans receive quality care in nursing homes.

HCFA, the agency that administers Medicare and oversees the state Medicaid programs:	
1.	Instructed states to impose immediate sanctions, such as fines, against nursing homes in more situations — including any time that a nursing home is found to have caused harm to a resident on consecutive surveys;
2.	Increased states' flexibility to encourage speedier action to stop payments for new admissions and to impose other sanctions when nursing homes violate federal health and safety requirements;
3.	Enhanced *Nursing Home Compare*, its consumer Internet resource found at ***www.medicare.gov***, to include information about the prevalence of bedsores, weight loss and other health conditions among residents in individual nursing homes; and
4.	Updated its "Guide to Choosing a Nursing Home" to take families and friends step-by-step through the process of identifying an appropriate home for a loved one.

"We are taking these actions to make sure that residents get the quality care and safe environment that they deserve," DeParle said. "HCFA and the states owe it to residents and their families to prevent problems where we can and address them quickly when they occur."

The recent actions extend the Clinton Administration's aggressive initiative to improve enforcement of federal and state standards and to promote quality care for 1.6 million elderly and disabled Americans in nearly 17,000 nursing homes. HCFA strengthened the inspection process to increase its focus on preventing bedsores, malnutrition and abuse, and it now requires states to crack down on homes that repeatedly violate health and safety requirements.

For Fiscal Year 2000, the President requested and secured more than $50 million in new resources to support the nursing-home initiative, including $18.1 million more for states' Medicare survey efforts and another $15.6 million in Medicaid matching funds available to states. Other resources will support federal oversight activities and increased legal activity related to enforcement.

More effective state inspections

HCFA recently issued additional instructions to the state agencies that conduct nursing-home inspections for Medicare and Medicaid. The instructions require immediate sanctions, such as fines, against nursing homes in more situations —including any time a nursing home is found to have caused harm to a resident on consecutive surveys. Nursing homes that do not fix the problems will lose their ability to receive Medicare and Medicaid payments.

To encourage sanctions to be imposed more quickly, states also received expanded authority to notify nursing homes when they would be denied payments for new admissions and other sanctions for failing to meet health and safety requirements. In addition, HCFA provided guidance for the use of a new enforcement tool that allows fines of up to $10,000 for each serious incident that threatens residents' health and safety. In the past, fines could only be based on the number of days that a nursing home failed to meet federal requirements.

HCFA this year has conducted an extensive training campaign for nursing-home inspectors to help states enforce federal requirements more effectively and consistently. Since this spring, HCFA has directly trained more than 600 federal and state survey managers, who have conducted training for their staff.

These actions follow other steps taken by HCFA this year to strengthen the state inspection and enforcement process.

These improvements include:	
1.	HCFA instructed state inspectors to increase their focus on preventing bedsores, malnutrition and abuse in nursing homes. HCFA also is piloting education campaigns to prevent abuse, neglect and malnutrition in nursing homes.
2.	HCFA established a new requirement for states to focus on complaints alleging harm to residents and conduct investigations within 10 days. In addition, states will continue to be required to investigate complaints alleging the most serious violations within two days, and other complaints in a timely manner.
3.	States now must conduct more frequent inspections of nursing homes that have repeated serious violations without decreasing inspections of other facilities.
4.	State inspectors now must make the timing of inspections unpredictable and must conduct some visits on weekends, early mornings and nights to look for quality, safety and staffing problems at those times.

Empowering consumers

To help consumers and advocates, HCFA also has added more data about residents' health status at all Medicare- and Medicaid-certified nursing homes to *Nursing Home Compare* at HCFA's consumer web site — ***www.medicare.gov.***

The web site now includes statistics reported by individual nursing homes about the prevalence of bedsores, incontinence and other health conditions, which can help consumers select an appropriate nursing

home. The web site, which already includes state inspection results about those homes, gives families and friends even more valuable information to help them make educated choices about nursing homes.

Users can search nursing homes by state, county or ZIP code, and compare data from two or more homes. The information comes from HCFA's Online Survey, Certification, and Reporting (OSCAR) database, which comprises survey data provided and updated by states. HCFA will continue to refine *Nursing Home Compare* to make it even more useful for consumers. Since testing began in September, 1998, the web site has recorded nearly 2.5 million pageviews.

The web site also includes an updated version of HCFA's "Guide to Choosing a Nursing Home," which is designed to take families step-by-step through the selection process. The guide includes questions to ask, a nursing-home checklist, contact information and other resources, as well as expanded information about preventing abuse and neglect. Consumers can obtain a printed copy of the guide by contacting the Medicare Choices Helpline at 1-800-MEDICARE (1-800-633-4227).

"Offering comparative information not only helps families and friends to make informed health care decisions, but also provides incentives for nursing homes to improve the quality of care," DeParle said. "No one should choose a nursing home based solely on an inspection report or statistics, but *Nursing Home Compare* makes it much easier to weigh that information in these decisions." ◆

Selected Health Issues on the Web

http://www.hhs.gov/news/press/1999pres/991022a.html

HHS Outlines New Rules for Research Integrity

The Department of Health and Human Services operates a collaborative system for promoting integrity in biomedical and behavioral research supported or conducted by agencies of the U.S. Public Health (PHS).

http://www.allanbaumgarten.com/

Reports Analyzing HMO Issues in a Particular Market (the Latest Market in Ohio)

As Tip O'Neill would have said, "All health care is local." Health plans, providers, employers, vendors and consumers all do business in local markets. To thrive, they need good objective analysis about managed care in local markets.

http://www.house.gov/waxman/drugs

Prescription Drug Price Discrimination

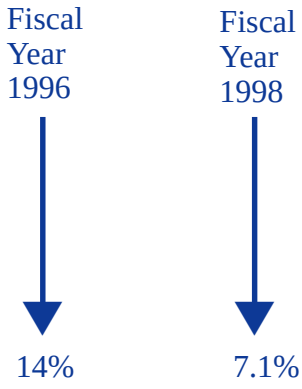
The high cost of prescription drugs is a vital issue for senior citizens across the country. Seniors have the greatest need for prescription drugs, accounting for one-third of all prescription drug sales, but often live on fixed incomes and have the most inadequate insurance coverage.

CLAIMS, from page 1

Under its new contract, Group Health, of New York, N.Y., will coordinate Medicare payments with other insurance companies by collecting, managing and reporting claims information. The national contract will streamline the process to ensure that health care claims are paid by the primary insurer — whether it is Medicare or another insurer — before uncovered expenses are sent to the secondary insurer.

Since Medicare's inception, Group Health has served as one of the private companies that Medicare, by law, hires to pay and process health care claims. Medicare will pay for the new national contract with a portion of the dedicated funds for program integrity established by HIPAA. The total cost of the contract will be $87 million over five years.

Medicare's Improper Payment Rate



Earlier this year, HCFA chose 13 other companies with special expertise in stopping and preventing waste, fraud and abuse as its first-ever Medicare Integrity Program contractors. Medicare is using those contractors to perform specific tasks to protect the Medicare Trust Fund, including audits, medical reviews, site visits and provider education efforts. Contractors have begun work on the first six assignments, and additional work orders are in development.

According to annual audits by the HHS Inspector General, Medicare's improper payment rate fell nearly in half over the past two years, from 14 percent in fiscal year 1996 to 7.1 percent in fiscal year 1998. The latest audit credits the Administration's anti-fraud and abuse efforts, HCFA's corrective action plan, and improved compliance by hospitals, doctors and other health care providers.◆

Visit *www.hcfa.gov*

New Steps Announced to Ensure Racial Equality in Kidney Transplantation

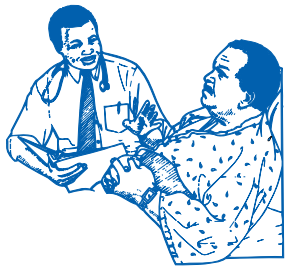
HCFA announced in November that the Medicare program is taking new steps to ensure that all patients with renal failure, regardless of race or ethnicity, are being evaluated for kidney transplantation.

The effort will include communication, enforcement and technical assistance to dialysis centers, which are required by regulation to assure that all patients in the facility are assessed for and fully informed about their suitability for transplantation as part of the patient's long-term care plan.

Medicare rules require that all patients with kidney failure be evaluated and informed about transplantation," said HCFA Administrator Nancy-Ann DeParle. “We want to be sure this is happening and be sure there is equal opportunity for transplantation when needed, regardless of a person's race."

The Medicare program provides insurance coverage for most Americans with permanent kidney failure, paying for dialysis treatment and transplantation through the End-Stage Renal Disease (ESRD) Program. Medicare covers a total of 310,000 ESRD patients, with estimated Fiscal Year 1999 pending of $11.8 billion.

HCFA 's announcement was made as a study by John Ayanian, M.D., and colleagues at Harvard Medical School which appeared in the *New England Journal of Medicine*. The investigators interviewed a sample of patients with kidney failure and found that black ESRD patients were less likely than white ESRD patients to want a transplant (76.3 percent vs. 79.3 percent among women, and 80.7 percent vs. 85.5 percent among men).



Racial differences were substantially greater in rates of referral for a transplant evaluation (50.4 percent for black women and 70.5 percent for white women, and 53.9 percent for black men vs. 76.2 percent for white men) and placement on a waiting list for transplantation within 18 months after starting dialysis (31.3 percent for black women vs. 56.5 percent for white women, and 35.3 percent for black men vs. 60.6 percent for white men). These racial differences remained significant after adjusting for patients' preferences and expectations about transplantations, sociodemographic characteristics, health status, perceptions of care and comorbid illnesses.

Medicare Web Site Wins Excellence Awards

In late 1999, the Health Care Financing Administration's web site, ***www.medicare.gov,*** won two achievement awards in recognition of the agency's efforts to get information to beneficiaries in new ways.

The web site won the first-place Gold Award for best government health care web site, and the second-place Silver Award for best site for seniors/boomers in the first annual Healthcare World Awards competition.

Everyone at HCFA is proud of ***www.medicare.gov***, and the staff members who created this outstanding web site,” said HCFA Administrator Nancy-Ann DeParle. “These honors reaffirm our commitment to providing top-flight consumer service to Medicare beneficiaries.”

The Healthcare World Awards recognize excellence in health care web site and online service development. Healthcare World is a forum of public, private and non-profit sector providers and users of online services in the health care field. The inaugural awards were announced on November 4 at the Healthcare World 1999 New York Conference. Awards were given in 30 categories.

The Medicare web site contains a broad range of useful information for consumers, including a complete description of the Medicare program, information on eligibility and enrollment, comparative information to help beneficiaries choose a managed care plan or a nursing home, a nationwide calendar of local activities and informational meetings, tips on how to fight fraud and abuse in the Medicare program, phone numbers to important information sources, wellness information (including flu and pneumonia immunizations), a directory of available publications, links to related contacts and information sources, and more.

www.medicare.gov is one part of the Medicare & You program, a national education campaign that also includes the *Medicare & You 2000* handbook, the Medicare Choices Helpline, 1-800-MEDICARE, (1-800-633-4227), and partnerships with hundreds of local and national organizations who work with Medicare beneficiaries all across the United States.

Created in 1998 by HCFA's Center for Beneficiary Services, the web site received 7.8 million “hits,” or visits, by computer users in October 1999. This translates into 1.4 million pageviews, double the number for October 1998.

“Two years ago, Medicare established the Center for Beneficiary Services specifically to serve the nearly 9 million seniors and disabled Americans who rely on Medicare,” DeParle said. “Easy-to-use information sources such as ***www.medicare.gov*** and 1-800-MEDICARE (1-800-633-4227) are the kinds of things Medicare had in mind for this innovative center dedicated to beneficiary needs.” ◆

Medicare will take a three-pronged approach to addressing transplant assessment disparities:	
1.	The program will remind all certified dialysis facilities of its requirements that all ESRD patients are to be assessed for and fully informed about transplantation as part of the patient's long-term care plan.
2.	HCFA will work with the State Survey Agencies in evaluating the study findings and paying particular attention to dialysis facility compliance with regulations. State Survey Agencies inspect ESRD and other health care facilities to determine their compliance with Medicare certification requirements.
3.	Medicare will work with the ESRD Network Organizations to identify ways that the networks can work with the patients, the renal community, and the dialysis facilities in their area to increase transplantation assessment rates. ESRD Network Organizations monitor the quality of care provided in dialysis facilities and assist facilities to improve patient care as opportunities present themselves.

"All three opportunities will enforce and reinforce Medicare's commitment to its ESRD beneficiaries by assuring that they will receive the quality of care that they depend on, including the opportunity to be fully informed about and assessed for transplantation," DeParle said. ◆

Calendar of Events — April and May 2000

April 18	Deputy Administrator Michael M. Hash addresses the National Cancer Legislation Advisory Committee in Washington, D.C., on *Overview of HCFA Programs and Authorities, and the Future Direction of the Nation's Cancer Research and Policy Opportunities.*
April 28	Deputy Administrator Hash speaks at the National Health Policy Forum in Annapolis, Md., on *Pulling Together: Aligning Legislative, Regulatory, and Delivery Imperatives.*
	Deputy Hash addresses the Medicaid Fraud and Abuse Commitment Conference in Washington, D.C., on *Fraud and Abuse in the Medicaid Program.*
May 2	Deputy Administrator Hash speaks at the National Program of All-inclusive Care for the Elderly (PACE) Association in Crystal City, Va., on *HCFA's Perspective on the Key Elements and Anticipated Application of the Interim Regulation.*
May 3	Administrator Nancy-Ann DeParle speaks at HCFA's Holocaust Memorial Ceremony in Baltimore, Md., on *The Administration's Commitment to Remembering the Holocaust.*
May 4	Administrator DeParle addresses the National Association of Urban Critical Access Hospitals in Washington, D.C., on *Medicare/Medicaid Disproportionate Share Payments.*
May 11	Deputy Administrator Hash speaks at the Bank of America Securities — Healthcare Institutional Investor Conference in Washington, D.C., on *Current HCFA InitiativesThat Impact HC Providers and Payers*.

Maine Is First State to Offer Treatment for Early HIV In Medicaid Demonstration

HHS Secretary Donna E. Shalala approved Maine's Medicaid demonstration plan to launch an early intervention and treatment program for HIV-positive individuals who do not yet have AIDS and who are not already eligible for Medicaid.

Recent research has shown that early intervention with AIDS-fighting drugs, including anti-retroviral therapies, can slow the progress of the disease. However, many people with HIV generally do not qualify for Medicaid — the state/federal partnership that provides health insurance to low-income young, aged, blind and disabled Americans — until they are considered disabled. This demonstration program will make drug therapies and treatment services available to HIV-positive people earlier in the course of their disease, delaying the onset of disability for many of these individuals.

Early intervention is also expected to reduce the need for costly hospitalization and to prevent the onset of opportunistic infections. HHS will closely monitor the Maine demonstration to identify any cost-savings to Medicaid during the five years of the demonstration.

Maine's Medicaid agency plans to begin the demonstration project this September. To be eligible, a participant must be HIV-positive and have an income of less than 300 percent of the federal poverty level (the poverty level is $8,350 for a person under age 65). The benefit package will include highly active anti-retroviral therapy, office visits, lab services, case management, hospitalizations, and mental health and substance abuse services. ◆

New Regulations/Notices

Medicare Program; Rural Health Clinics; Amendments to Participation Requirements and Payment Provisions; and Establishment of a Quality Assessment and Performance Improvement Program [HCFA–1910–P] — Published 2/28. This proposed rule would amend our regulations to revise certification and payment requirements for Rural Health Clinics (RHCs) as required by the Balanced Budget Act of 1997 (BBA 1997). It would include new refinements of what constitutes a qualifying rural shortage area in which a Medicare RHC must be located; establish criteria for identifying RHCs essential to delivery of primary care services that can continue to be approved as Medicare RHCs in areas no longer designated as medically underserved; and limit waivers of certain nonphysician practitioner staffing requirements. It also would impose payment limits on provider-based RHCs and prohibit "commingling" the use of space, equipment, and other resources of an RHC with another entity. Finally, the rule would require RHCs to establish a quality assessment and performance improvement program that goes beyond current regulations. This proposed rule would make other revisions for clarity and uniformity and to improve program administration. Comments will be considered if HCFA receives them at the appropriate address, as provided below, no later than 5 p.m. on April 28, 2000. Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1910–P, P.O. Box 26676, Baltimore, MD 21207-0476.

Medicare Program; Payment Amount If Customary Charges Are Less Than Reasonable Costs; Technical Amendments [HCFA–1860–FC] — Published 2/22. In accordance with HCFA's regulatory burden reduction program, this technical regulation modifies or removes from regulations language that references the following aspects of the Medicare program: The Lower of Cost or Charges (LCC) carryover provision; this provision was removed from HCFA regulations several years ago. The application of the LCC principle to durable medical equipment (DME) furnished by home health agencies (HHAs); these items are now paid in accordance with a fee schedule. These regulations are effective on March 23, 2000.

Medicare and Medicaid Programs; Reapproval of the Deeming Authority of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) for Home Health Agencies (HHAs) [HCFA–2058–FN] — Published 2/22. This notice announces the reapproval of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a national accreditation organization for home health agencies (HHAs) that request participation in the Medicare program. Therefore, HHAs accredited by JCAHO will be granted deemed status under the Medicare program. This final notice is effective February 22, 2000, through March 31, 2005.

Medicare and Medicaid Programs; Reapproval of the Deeming Authority of the Community Health Accreditation Program, Incorporated (CHAP) for Home Health Agencies (HHAs) [HCFA– 2059–FN] — Published 2/22. This notice announces the reapproval of the Community Health Accreditation Program, Incorporated (CHAP) as a national accreditation organization for home health agencies (HHAs) that request participation in the Medicare program. HCFA has found that CHAP's standards for HHAs meet or exceed those established by the Medicare program. Therefore, HHAs accredited by CHAP will be granted deemed status under the Medicare program. This final notice is effective February 22, 2000, through March 31, 2005.

Medicare and Medicaid Programs; Recognition of the American Osteopathic Association (AOA) for Continued Approval of Deeming Authority for Hospitals [HCFA–2057–FN] — Published 2/22. This notice announces the reapproval of the American Osteopathic Association (AOA) as a national accreditation organization for hospitals that request participation in the Medicare program. HCFA believes that continuing accreditation of hospitals by AOA demonstrates that all Medicare hospital conditions of participation are met or exceeded. Thus, HCFA grants deemed status to those hospitals accepted by AOA. This final notice is effective February 22, 2000, through March 31, 2005.

Visit
www.hcfa.gov

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